IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

March 17, 2010

Kerrie McCarthy
1137 East 2nd Street
Weiser, ID 83672

Dear Ms. McCarthy:

We have received your complaint regarding Weiser Memorial Hospital.

We will schedule an unannounced visit to the facility to conduct an investigation as soon as possible. Upon completion of our investigation, we will notify you of our findings.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

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May 17, 2010

Wade Johnson
Weiser Memorial Hospital
645 East 5th Street
Weiser, ID 83672

RE: Weiser Memorial Hospital, provider #131307

Dear Mr. Johnson:

This is to advise you of the findings of the complaint survey at Weiser Memorial Hospital which was concluded on May 4, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **May 31, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131307	A. BUILDING _____ B. WING _____	C 05/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEISER MEMORIAL HOSPITAL	645 EAST 5TH STREET WEISER, ID 83672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your Critical Access Hospital. The surveyors conducting the survey were: Teresa L Hamblin, RN, MS, Team Leader Aimee Hastriter, RN, BS, HFS Abbreviations include: CAH = Critical Access Hospital COPD = Chronic Obstructive Pulmonary Disease CPM = Continuous Passive Motion ED = Emergency Department PCA = Patient Controlled Analgesia PT = Physical Therapy OT = Occupational Therapy RN = Registered Nurse ST = Speech Therapy TED = Thrombo-Embolism Deterrent	C 000	RECEIVED JUN 02 2010 FACILITY STANDARDS	
C 298	485.635(d)(4) NURSING SERVICES A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure nursing care plans were developed, individualized, or kept current based on nursing assessments in 10 of 10 records (#1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) reviewed. This had the potential to negatively impact quality, thoroughness, and coordination of patient care. Findings include: An undated CAH policy, "Care Planning," stated care planning was to be individualized according to the patient's needs, strengths, limitations,	C 298	Response to C 298: 485.635(d)(4) NURSING SERVICES Action: Policy & Procedure Revision. The Care Planning policy and procedure will be revised and the date of revision recorded. The revision will include the process for individualizing the care plan to meet the needs of the patient. The policy and procedure will also address the continual evaluation and revision of the individualized care plan based on the patient's changing clinical condition, care goals, plan for treatment and assessment findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 5/27/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 298	Continued From page 1 goals, and diagnoses. Care planning was expected to be based on data collected from assessments and would be regularly reviewed and revised. The policy did not specifically address how nursing staff were expected to individualize pre-printed nursing care plans or show evidence of revisions. A staff RN was interviewed on 5/04/10 at 1:40 PM. She explained that the admitting RN completed the initial patient assessment and subsequently developed a care plan based on the nursing assessments. Some care plans were standardized and some hand written. When asked how the pre-printed care plans were individualized for patients, she explained that relevant information was circled, or initialed and information that did not apply would be crossed out. She stated if patient health conditions affected patient care, then the information should be addressed on a care plan. If a physician ordered a discipline, such as PT, OT, ST, or swallowing evaluation, it should be included on the patient's care plan. She stated if a patient was assessed to be at high risk for falls, then the fall risk protocol should be initiated and placed in the patient's medical record. Similarly, if a patient was determined to be at risk for skin breakdown, then the skin protocol should be initiated and placed in the medical record. During an interview on 5/03/10 at 3:15 PM, the Director of Medical-Surgical Unit acknowledged the green pre-printed care plans were not individualized. She stated it was a concern to her and she planned to do some work around improving the care planning process. In the following examples, the CAH failed to either	C 298	Action: Care Plan re-training. Nursing staff will participate in a care plan in-service demonstrating the implementation and documentation of properly executed care plans. A roster will be maintained assuring all nursing staff have participated. Responsibility: The Chief Nursing Officer will be responsible for implementation of the plan of correction for care plans. Improvement in processes: The actions will improve processes by providing the nursing staff with skills and tools necessary for executing quality and compliant care plans. Procedure for implementation: The Director of Med/Surg will revise the care plan policy and procedure. The Education Coordinator and Chair of the nursing education council will execute the care plan re-training. The nursing quality council will audit charts and the Director of Quality Management will track compliance. Deficiency correction completion date: 7/31/2010 Monitoring and tracking procedures: The nursing quality council will audit 12 patient charts per month for 3	

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C 298	Continued From page 2 individualize pre-printed care plans or to utilize assessment data to develop or revise care plans based on assessment findings. 1. Patient #8 was an 86 year old female admitted on 3/14/10. A History and Physical Report, dated 3/15/10, indicated Patient #8 arrived in the ED with vomiting and diarrhea and had a urinary tract infection. She was assessed to be dehydrated. She also had a history of Alzheimer's dementia with aggressive behaviors. The Initial Nursing Assessment, dated 3/14/10, documented the patient was verbally abusive/yells/swears and was physically abusive/combative. She was assessed to be at high risk of falls. She was also assessed to have a reddened area above her coccyx. There were no care plans present in the medical record that addressed aggressive behaviors, fall risk, dehydration, diarrhea, or risk for skin breakdown. There was a care plan that addressed "urinary tract infection." During an interview on 5/04/10 at 12:00 PM, the Director of the Medical-Surgical Unit reviewed the record and confirmed the findings. Care planning was incomplete. 2. Patient #4 was a 92 year old male admitted to the hospital on 3/13/10 for weakness. An Admission Assessment, dated 3/13/10, indicated Patient #4 was assessed to be at high risk for falls. He also had dementia. There were no nursing care plans present in his medical record. During an interview on 5/02/10 at 3:15 PM, the Director of the Medical-Surgical Unit reviewed Patient #4's medical record and confirmed the findings. At 3:55 PM on 5/03/10, she provided a copy of a pre-printed "fall risk care plan" and	C 298	months. The monitoring and tracking process will ensure care plans - • Identify the patient's problems/needs. • Each identified problem has a goal/aim. • Goals are realistic and attainable. • The short and long term goal(s) have identified nursing interventions. • Interventions are realistic and measurable. • Care plans are appropriately authenticated and dated. • Patient/family has agreed with the plan of care. • Risks are identified and the care plan states how the risk will be managed. • The care plan is up to date. • Pertinent signs and symptoms are observed in regards to the patient's problems and are managed. • Care plan includes non-nursing activities/therapies, socio-psychological needs. • The information is systematic and easy to find.	

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C 298	Continued From page 3 stated if a patient was assessed to be at fall risk she would expect to see the care plan in the medical record. 3. Patient #9 was a 94 year old female admitted to the hospital on 4/05/10 for care related to a pulmonary embolism. She also had a history of diabetes, urge incontinence, and fatigue. She was assessed at admission by nursing to be at high risk for falls. There were no nursing care plans present in Patient #9's medical record. During an interview on 5/04/10 at 3:15 PM, the Chief Nursing Officer reviewed the medical record and confirmed the findings. She stated the care plans may have been transferred to a swing bed chart; however, she was not able to verify this information. 4. Patient #1 was a 73 year old female who had knee surgery on 4/26/10. Nursing documentation, dated 4/28/10, documented nursing interventions and/or medical treatments for Patient #1 to include CPM machine, hemovac drain, foley catheter, TED hose, and PCA pump. These interventions were not included in Patient #1's care plan. A pre-printed care plan, "Knee Replacement," was present in her medical record. It did not include Patient #1's name on it. The care plan included nine pre-printed nursing diagnoses with corresponding outcomes and interventions. None of the nursing diagnoses, outcomes, or interventions were checked or circled to indicate they had been individualized or specifically selected for Patient #1. Three of the nursing diagnoses had hand written dates next to the diagnoses stating they had been started, evaluated, or met. Six of the nursing diagnoses	C 298		

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C 298	Continued From page 4 did not have any individualized dates or notes written next to them. It was unclear as to which pre-printed interventions were relevant and being implemented. During an interview on 5/03/10 at 3:15 PM, the Director of Medical-Surgical Unit acknowledged the pre-printed care plans were not individualized and stated she was working towards improvement in this area. She stated she was unsure if nursing staff were re-evaluating the care plan on a daily basis. 5. Patient #6 was an 86 year old male admitted on 4/13/10 with chest pain and a pulmonary embolus. He was treated during the hospitalization with anticoagulation therapy to "thin the blood." An undated discharge instruction sheet, titled "Warfarin and Anticoagulation Therapy," cautioned against the dangers of the therapy and the importance of taking the therapy seriously to avoid grave consequences, including death and disability. A pre-printed care plan, dated 4/15/10, addressed the need to monitor and address Patient #6's pain. However, there was no care plan in the medical record to address monitoring for side effects of the medication during the admission or educating the patient/caregiver regarding the risks and side effects of the medication. Although the hospital had a pre-printed care plan to address nursing care interventions related to pulmonary embolism, the care plan was not included in Patient #6's medical record. During an interview on 5/04/10 at 11:45 AM, the Director of the Medical-Surgical Unit reviewed the record and confirmed the findings.	C 298		

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C 298	Continued From page 5 6. Patient #3 was an 81 year old female admitted to the hospital on 3/05/10 with a primary diagnosis of pneumonia. Secondary diagnoses included, but were not limited to, dementia, dehydration, diabetes, dysphagia, malaise and fatigue. Physician orders, dated 3/08/10, called for PT evaluation and treatment for ataxia and weakness and a speech evaluation related to aspiration risk. Physician orders, dated 3/09/10, called for Patient #3 to sleep on a wedge pillow and receive intermittent supervision during meals to avoid aspiration. None of these orders were incorporated into care planning. During an interview on 5/04/10 at 11:55 AM, the Director of the Medical-Surgical Unit reviewed the record and confirmed the findings. The medical record included a pre-printed care plan, titled "Pneumonia" which included five related nursing diagnoses. None of the nursing diagnoses, outcomes, or interventions were checked or circled to indicate they had been individualized or specifically selected for Patient #3. One of the nursing diagnoses had hand written dates next to the diagnosis stating it had been initiated and evaluated. Four of the nursing diagnoses did not have any individualized dates or notes written next to them. 7. Patient #10 was an 87 year old male admitted to the hospital on 3/23/10 via the emergency room. The History and Physical Report, completed by the physician on 3/23/10, indicated he presented with a fever of unknown origin and he was to be evaluated for sepsis. The Identification and Background Information form was completed by the nurse on 3/23/10, and indicated Patient #10 was at a high risk for falls.	C 298		

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C 298	Continued From page 6 A pre-printed care plan titled "fever of unknown origin" was located in Patient #10's medical record. It contained three problems related to this diagnosis, with corresponding outcomes, time frames, and interventions. At the bottom of the page, a nurse indicated the care plan had been initiated on 3/23/10 at 2:00 PM. A second nurse documented the care plan had been evaluated on 3/24/10. A third nurse documented the patient had been discharged on 3/25/10 at 9:15 AM. No additional documentation was present to indicate which outcomes and interventions were pertinent for Patient #10. A physician's progress note, dated 3/24/10 at 7:50 AM, was hand written in the medical record. The physician noted that the urine culture was positive, therefore the fever of unknown origin was likely related to a urinary tract infection/urosepsis. The "24 Hour Record," dated 3/24/10, indicated that the day shift and the night shift RNs had evaluated the care plan. However, the care plan was not updated to reflect the new, more specific, diagnosis of urinary tract infection. An updated care plan would have included problems, outcomes, and interventions specific to a urinary tract infection. The Chief Nursing Officer was interviewed on 5/04/10 at 3:24 PM. She reviewed Patient #10's medical record. She agreed that she would have expected the care plan to be updated and revised in accordance with the change in diagnosis from fever of unknown origin to urinary tract infection/urosepsis. She stated a care plan related to Patient #10's high risk for falls should have been included in the medical record.	C 298		

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C 298	Continued From page 7 8. Patient #2 was a 95 year old female admitted to the hospital on 4/25/10, after being treated in the emergency room where she was taken after being found on the floor by family members. The History and Physical Report, completed by the physician on 4/25/10, indicated she was treated for pneumonia, peripheral edema, and bilateral knee osteoarthritis. Admitting physician orders from 4/25/10 at 10:20 PM, included placing Patient #2 on aspiration and fall precautions and evaluation by physical and occupational therapy. However, these orders and subsequent treatments were not found on a care plan for Patient #2. Nursing narrative notes dated 4/26/10 at 1:00 PM, documented the RN "Placed sacral dressing to sacrum due to very red, non-blanching skin that has two areas that appear to be on the verge of broken skin." However, the medical record did not contain a care plan around pressure ulcer treatment or prevention. The care plan for Patient #2 was a pre-printed care plan titled "Pneumonia." The document included five pre-printed nursing diagnoses with corresponding outcomes, time frames, and interventions. The document was marked at the bottom of the first page with the date 4/27/10, an RN's signature, and the word "initialed [sic]." The care plan did not contain Patient #2's name, and there was no indication that the care plan had been individualized for Patient #2 with appropriate outcomes and/or interventions selected. In addition, the medical record did not contain a care plan to address Patient #2's issues such as peripheral edema, aspiration and fall risks, skin integrity, or the osteoarthritis which was addressed by therapy services and trial	C 298		

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C 298	Continued From page 8 medications. A staff LPN was interviewed on 5/03/10 at 3:25 PM. She stated that a patient who was evaluated to be a fall risk will be identified by a symbol placed on the door of their room. She stated there was a fall risk care plan; however staff generally passed along information related to fall risk interventions during oral report given at shift change. The Chief Nursing Officer and the Director of the Medical-Surgical Unit were interviewed together on 5/04/10 at 11:45 AM. They reviewed Patient #2's medical record and agreed that issues such as mobility related to arthritis, fall risk, and skin integrity should have been addressed in a care plan, and that the care plan related to pneumonia was not individualized. On 5/04/10 at 12:35 PM, the Chief Nursing Officer presented pre-printed care plans available to staff related to alterations or potential alterations in skin integrity, altered oral and/or nutritional status, and alterations in respiratory functions. She stated she would expect the appropriate care plan to be in the medical record. 9. Patient #7 was an 82 year old male admitted to the hospital on 4/04/10 for treatment of pneumonia. The History and Physical Report, dictated by the physician on 4/04/10, indicated Patient #7 had additional diagnoses of diabetes, hypertension, mild renal insufficiency, elevated blood lipid levels, and COPD. The Identification and Background Information form, completed by a nurse on 4/04/10, indicated Patient #7 was at a high risk for falls.	C 298		

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C 298	Continued From page 9 The care plan found in Patient #7's medical record was a pre-printed care plan titled "Pneumonia." Hand written notes on the first page of the care plan indicated the plan was implemented on 4/04/10 at 11:00 PM. A second notation indicated the care plan had been evaluated on 4/06/10 at 3:15 AM. The care plan did not contain Patient #7's name and was not marked in any way to indicate which problems, outcomes, or interventions were applicable to him. Patient #7's medical record did not contain a care plan related to fall risk or any of his secondary diagnoses. The Chief Nursing Officer and the Director of the Medical-Surgical Unit were interviewed together on 5/04/10 at 11:45 AM. They reviewed Patient #7's medical record and confirmed lack of adequate care planning. The Director of the Medical-Surgical Unit stated that Patient #7's COPD was troublesome for him during his hospitalization and required interventions. 10. Patient #5 was a 75 year old male admitted to the hospital on 4/05/10, subsequent to a left total knee arthroplasty. The Identification and Background Information form was completed by the surgical nurse prior to surgery on 4/05/10. It indicated Patient #5 had a history of diabetes, hypertension, arthritis, and an anxiety disorder. According to this document, Patient #5 was not considered a fall risk prior to surgery. However the fall risk assessment was not repeated once surgery had been completed. Nursing documentation revealed Patient #5's blood glucose level ranged from 150 to 240. According to the American Diabetes Association,	C 298		

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C 298	Continued From page 10 at www.diabetes.org, with a copyright of 2010, the normal range for blood glucose was 70-130 (fasting level) to less than 180 (after a meal). Documentation on 4/07/10, in the "24 Hour Record," indicated Patient #5 consumed several pieces of chocolate candy which he believed were sugar free. His blood glucose was subsequently 240. The medical record did not contain information related to the physician's expectations for Patient #5's blood sugar levels or what, if any, education was needed or had been discussed. No care plan related to diabetes had been initiated. The medical record did contain a care plan titled "Knee replacement." The pre-printed care plan contained nine nursing diagnoses along with outcomes, time frames, and interventions. Hand written documentation, which included dates and the RN's signature at the bottom of the first page of the care plan, indicated the care plan was started on 4/05/10, and evaluated on 4/06/10 and 4/07/10. The care plan did not contain Patient #5's name, and other than the above documentation, the care plan had not been marked to indicate appropriate outcomes and interventions specifically intended for Patient #5. The pre-printed care plan for knee replacements did not contain pain control as a problem or potential problem for Patient #5. Therefore, the medical record did not contain a care plan for pain management for Patient #5 after his surgery. The Chief Nursing Officer and the Director of the Medical-Surgical Unit were interviewed together on 5/04/10 at 11:45 AM. They reviewed Patient #5's medical record and agreed that the care plan was not individualized to meet Patient #5's needs.	C 298		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 298	Continued From page 11 The Director of the Medical-Surgical Unit agreed the fall risk should have been re-evaluated after surgery. She stated that Patient #5 required guidance and re-education related to post-surgical protocols and diabetes management and agreed that these issues should have been addressed in a patient-specific care plan. A staff RN was interviewed on 5/04/10 at 1:40 PM regarding the development and use of care plans. She reviewed Patient #5's medical record and stated that if a patient has a secondary diagnosis, such as diabetes for Patient #5, it should be addressed on a care plan. She also stated she thought pain management was addressed on the surgical care plans, however, after review confirmed this was not true for Patient #5. The hospital failed to ensure care plans were developed, individualized, or kept current based on nursing assessments and patient needs.	C 298		
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure admission consent documentation was complete in 6 of 10 patients' records (#1, #3, #5, #6, #8, and #9) reviewed. This resulted in a lack of clarity as to the course and timing of consent. Findings include: 1. Patient #1's signature was on the Admission Consent for Treatment. However, the consent	C 302	Response to C 302: 485.638(a)(2) RECORDS SYSTEMS Action: Staff re-training. Admission, Health Unit Coordinator, and patient care personnel will participate in patient admission in-service which will demonstrate complete documentation of properly executed patient admission consent. A participation roster will be maintained. Responsibility: The Revenue Cycle Director will be responsible for implementation of the plan of correction for record systems.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131307	A. BUILDING _____ B. WING _____	C 05/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEISER MEMORIAL HOSPITAL	645 EAST 5TH STREET WEISER, ID 83672

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C 302	Continued From page 12 form was undated and untimed. During an interview on 5/03/10 at 11:30 AM, the Chief Nursing Officer reviewed the medical record and confirmed the missing date and time. 2. Patient #3 was an 81 year old female admitted to the hospital on 3/05/10. Patient #3's Admission Consent for Treatment was signed by an agent or representative. However, the consent form was undated and untimed. During an interview on 5/04/10 at 11:55 AM, the Director of the Medical-Surgical Unit reviewed the consent form and confirmed the findings. 3. Patient #6 was an 86 year old male admitted on 4/16/10. There was no Admission Consent for Treatment present in the medical record. During an interview on 5/04/10 at 11:45 AM, the Director of the Medical-Surgical Unit reviewed the medical record and confirmed the consent form was missing. 4. Patient #8 was an 86 year old female admitted on 3/14/10. Patient #8's Admission Consent for Treatment was signed by an individual that identified himself as having power of attorney. The consent form was undated and untimed. During an interview on 5/04/10 at 12:00 PM, the Director of the Medical-Surgical Unit reviewed the consent form and confirmed the findings. 5. Patient #9 was a 94 year old female admitted on 4/05/10. The Admission Consent for Treatment was signed and dated by the patient. The time the document was signed was blank. During an interview on 5/04/10 at 3:15 PM, the Chief Nursing Officer reviewed the consent and confirmed the time the consent was obtained was missing.	C 302	Improvement in processes: The actions will improve processes by providing the admission, Health Unit Coordinator, and patient care personnel with skills and tools necessary for executing quality and compliant patient admission consent documentation. Procedure for implementation: The Revenue Cycle Director will provide re-training activities to appropriate personnel. The Health Information Management Department will audit for signed, dated and timed patient admission consents which are placed in the medical record as an on-going department quality indicator. Deficiency correction completion date: 6/15/2010 Monitoring and tracking procedures: The Health Information Management Department will audit every chart for a signed, dated, timed and witnessed admission consent document that is placed in the medical record. The audit results will be submitted as the departments' quality indicator to the Director of Quality Management on a monthly basis to be benchmarked as part of the hospital wide quality improvement program. The Director of Quality Management will track compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 302	Continued From page 13 6. Patient #5 was a 75 year old male admitted to the hospital on 4/05/10. The Admission Consent for Treatment was signed by Patient #5, but was not dated or timed. In an interview on 5/03/10 at 1:25 PM, the Chief Nursing Officer reviewed the medical record and confirmed the missing date and time. The hospital failed to ensure admission consent documentation was complete, with date and time, and placed in the medical record.	C 302		

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation survey of your Critical Access Hospital. The surveyors conducting the survey were: Teresa L Hamblin, RN, MS, Team Leader Aimee Hastriter, RN, BS, HFS	B 000		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to federal tag C298 as it relates to the failure of the CAH to ensure care plans were developed, individualized, and kept current.	BB175	Response to BB175: 16.03.14.310.03 Patient Care Plans: The plan of correction as outlined and referenced in response to C 298: 485.635(d) (4) NURSING SERVICES will ensure care plans are developed, individualized and kept current for each inpatient. RECEIVED JUN 02 2010 FACILITY STANDARDS	
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall	BB283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BB283	Continued From page 1 contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, farnily history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88)	BB283	Response to BB283: 16.03.14.360.12 Record Content: The plan of correction as outlined and referenced in response to C 302: 485.638(a) (2) RECORDS SYSTEMS will ensure admission consent documentation is complete.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BB283	Continued From page 2 i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to federal tag C 302 as it relates to the failure of the CAH to ensure admission consent documentation was complete.	BB283		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

May 17, 2010

Wade Johnson
Weiser Memorial Hospital
645 East 5th Street
Weiser, ID 83672

Provider #131307

Dear Mr. Johnson:

On **May 4, 2010**, a complaint survey was conducted at Weiser Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004569

Allegation #1: The hospital staff failed to respond to the toileting needs of patients in a timely manner.

Findings: An unannounced visit was made to the hospital on 5/03/10 and 5/04/10. During the complaint investigation, surveyors reviewed hospital policies, patient satisfaction surveys, complaint records, and ten patient records. They also interviewed nursing staff, administrative staff, CNA (certified nursing assistant) students, and two current patients and two discharged patients.

All of the patients interviewed expressed satisfaction with the hospital staffs' responsiveness to call lights and toileting needs, as well as other needs.

Patient comments written in Patient Satisfaction surveys and patient complaint letters were reviewed for the last quarter. There were no complaints listed on the surveys or complaint letters that related to a lack of responsiveness by nursing staff to call lights or toileting needs. The satisfaction survey results showed 100 percent of respondents rated the overall quality of services received at the hospital as good or very good.

Three former CNA students were interviewed by phone. Two students described positive experiences. One student described a negative experience. She stated she notified nursing staff (CNA and nurse) two times that a patient was asking for help to get up. She was told to go back and distract the patient. She stated nursing staff did not respond to the patient until after he had gotten himself out of bed and soiled himself. The CNA student reported feeling badly about the patient's distress and humiliation at having messed his pants. She also expressed being upset about what she perceived as a lack of responsiveness to a patient's needs on the part of a CNA and a nurse. She did not remember the name of the patient. The incident could not be verified.

Although it could not be verified hospital staff failed to respond to toileting needs in a timely manner, it was determined through record review the hospital failed to develop care plans to ensure the needs of patients were adequately met, including toileting needs. The hospital was cited with deficiencies at Code of Federal Regulations 485.635(d)(4) and State Rules 16.03.14.310.03 for failure to initiate or revise individualized care plans based on assessment findings.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Hospital nursing staff failed to appropriately supervise CNA students.

Findings: The Nurse Educator was interviewed on 5/04/10 at 9:25 AM. She explained that when a CNA student was in the facility, they would be assigned to work with a CNA. If a CNA was not available, the student would be assigned to work with a nurse. She explained CNA students were not to do tasks independently. Instead, they were to work alongside their assigned staff member.

A CNA Unit Coordinator was interviewed on 5/04/10 at 11:30 AM. She similarly stated CNA students worked side by side with CNAs and did not work independently.

One current patient was asked about her experience with students. She stated "students don't come in by themselves."

Three former CNA students were interviewed by telephone. All of the students stated they provided patient care under the supervision of an assigned CNA or nurse. One student expressed frustration with her experience as a student because she became aware of a patient who needed help to get up and go to the bathroom. Since she was not allowed to help him by herself, she notified her assigned CNA and nurse of the patient's need to get up and go to the bathroom. She stated she did not act independently even though she would have liked to help the patient.

A high school student who was part of a career-based learning class was present at the time of the survey. She was shadowing an RN. She stated she did not do anything independently.

It could not be determined the hospital failed to provide adequate supervision to CNA students.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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C.L. "BUTCH" OTTER – Governor
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P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

May 17, 2010

Kerrie McCarthy
1137 East 2nd Street
Weiser, ID 83672

Dear Ms. McCarthy:

On **May 4, 2010**, a complaint survey was conducted at Weiser Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004569

Allegation #1: The hospital staff failed to respond to the toileting needs of patients in a timely manner.

Findings: An unannounced visit was made to the hospital on 5/03/10 and 5/04/10. During the complaint investigation, surveyors reviewed hospital policies, patient satisfaction surveys, complaint records, and ten patient records. They also interviewed nursing staff, administrative staff, CNA (certified nursing assistant) students, and two current patients and two discharged patients.

All of the patients interviewed expressed satisfaction with the hospital staffs' responsiveness to call lights and toileting needs, as well as other needs.

Patient comments written in Patient Satisfaction surveys and patient complaint letters were reviewed for the last quarter. There were no complaints listed on the surveys or complaint letters that related to a lack of responsiveness by nursing staff to call lights or toileting needs. The satisfaction survey results showed 100 percent of respondents rated the overall quality of services received at the hospital as good or very good.

Three former CNA students were interviewed by phone. Two students described positive experiences. One student described a negative experience.

She stated she notified nursing staff (CNA and nurse) two times that a patient was asking for help to get up. She was told to go back and distract the patient. She stated nursing staff did not respond to the patient until after he had gotten himself out of bed and soiled himself. The CNA student reported feeling badly about the patient's distress and humiliation at having messed his pants. She also expressed being upset about what she perceived as a lack of responsiveness to a patient's needs on the part of a CNA and a nurse. She did not remember the name of the patient. The incident could not be verified.

Although it could not be verified hospital staff failed to respond to toileting needs in a timely manner, it was determined through record review the hospital failed to develop care plans to ensure the needs of patients were adequately met, including toileting needs. The hospital was cited with deficiencies at Code of Federal Regulations 485.635(d)(4) and State Rules 16.03.14.310.03 for failure to initiate or revise individualized care plans based on assessment findings.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Hospital nursing staff failed to appropriately supervise CNA students.

Findings: The Nurse Educator was interviewed on 5/04/10 at 9:25 AM. She explained that when a CNA student was in the facility, they would be assigned to work with a CNA. If a CNA was not available, the student would be assigned to work with a nurse. She explained CNA students were not to do tasks independently. Instead, they were to work alongside their assigned staff member.

A CNA Unit Coordinator was interviewed on 5/04/10 at 11:30 AM. She similarly stated CNA students worked side by side with CNAs and did not work independently.

One current patient was asked about her experience with students. She stated "students don't come in by themselves."

Three former CNA students were interviewed by telephone. All of the students stated they provided patient care under the supervision of an assigned CNA or nurse. One student expressed frustration with her experience as a student because she became aware of a patient who needed help to get up and go to the bathroom. Since she was not allowed to help him by herself, she notified her assigned CNA and nurse of the patient's need to get up and go to the bathroom. She stated she did not act independently even though she would have liked to help the patient.

A high school student who was part of a career-based learning class was present at the time of the survey. She was shadowing an RN.

She stated she did not do anything independently.

It could not be determined the hospital failed to provide adequate supervision to CNA students.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Even though incidents or events may have occurred as you described them, it is not always possible to find evidence that corroborate or substantiates each allegation in the complaint. When the allegation is referred to as unsubstantiated, it means that noncompliance with a regulation could not be proven. It does not mean that an incident did not occur or that a family member/visitor did not witness a problem. It means that an allegation could not be confirmed through the investigation process or the facility took corrective measures prior to the investigation.

Based on the findings of the investigation, the facility was required to submit a Plan of Correction in writing to this office. In their Plan of Correction, they stated the actions taken to correct each deficiency and a date it would be completed. A copy of the survey results may be obtained, after the Department of Health and Welfare, Bureau of Facility Standards has released it for public disclosure, through the Internet at www.facilitystandards.idaho.gov, posted under survey results, or through a Public Records Request. The contact information for making a Public Records Request is at www.healthandwelfare.idaho.gov/AboutUs/PublicRecordsRequest, or you may call 208/334-5564 or the fax number is 208/334-6558. Please allow a minimum of 60 days after survey exit for posting. The Department will continue to monitor the progress of the facility.

Thank you for bringing these concerns to our attention. If you have any questions or if we can assist you further, please do not hesitate to contact this office at (208) 334-6626.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw